WISCONSIN MEDICAID
REGISTRATION TO RECEIVE REPORT OF MEDICAID-ELIGIBLE STUDENTS FOR SCHOOL-BASED SERVICES PROVIDERS

Wisconsin Medicaid requires certain information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. All child-specific information that is sent and received from the Medicaid Administrative Claiming (MAC)/School-Based Services (SBS) Web site is completely *confidential* and *must be used only for school-based services' eligibility verification*. Disclosure of *any* child-specific information from the database is prohibited by state and federal law and is subject to criminal prosecution. The information may be shared with others in the school district/Cooperative Educational Service Agency *only* for purposes directly associated with the administration of the state plan within the meaning of 42 CFR s. 431.303.

By completing this form, SBS providers may access the MAC/SBS Web site at *www.wisconsinedi.org/macsbs/* and receive student Medicaid eligibility information from Wisconsin Medicaid. Wisconsin Medicaid will send the student eligibility information to each SBS provider in an e-mail with a password-protected, encrypted text file. Providers should use this form to establish a password and the contact person to whom the report will be sent. The use of this form is voluntary, and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

Note: The password that the providers will create for the encrypted text file may not be the same as the password that users will use to logon to the MAC/SBS Web site.

Instructions: Type or print clearly.

Name — Contact Person	Telephone Number — Contact Person
E-mail Address — Contact Person	
Name — School District / Cooperative Educational Service Agency (CESA)	
Telephone Number — School District / CESA	Fax Number — School District / CESA
SBS Provider's Medicaid Provider Number	
Password (Password must consist of eight characters and must contain at least one alphabetic and one numeric character. Passwords are case sensitive.)	
SIGNATURE — Contact Person	Date Signed

Return this completed form to the Division of Health Care Financing Electronic Data Interchange (EDI) Department:

Division of Health Care Financing
EDI Department
6406 Bridge Rd
Madison WI 53784-0009

Providers may contact the EDI Department with questions by telephone at (608) 221-9036 or via e-mail at *wiedi@dhfs.state.wi.us*.

Reset Form